STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155072	A. BUILDING 00 B. WING	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEECH GROVE MEADOWS	2002 ALBANY ST BEECH GROVE, IN46107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Recertification and State Licensure survey. This visit included the investigation of complaint # IN00094241. Complaint IN00094241 Substantiated, no deficiencies related to the allegations are cited. Survey dates: July 25, 26, 27, 28, 29, and August 1st, 2011 Facility number: 000029 Provider number: 155072 AIM number: 100275200 Survey team: Leia Alley, RN, TC Marcy Smith, RN Barbara Hughes, RN Patty Allen, BSW (July 25th thru 29th, 2011) Courtney Mujic, RN (July 28th & 29th, 2011) Census bed type: SNF: 19 SNF/NF: 109 Residential: 13 Total: 141 Census payor type:	F0000	This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after 8/29/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicaid: 71 Medicare: 32 Other: 38 Total: 141 Sample: 24 Supplemental sample: 1 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/5/11 Cathy Emswiller RN			
F0242 SS=D	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on record review and interview, the facility failed to ensure residents were treated with respect during night time hours by asking them to awaken and take early morning or overnight showers. This affected 2 of 11 people interviewed for shower times preferences in a sample of 24. [Resident #'s 18 and 68]	F0242	F 242 Self determination, right to make choices. This provider ensures that the resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are	08/29/2011

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	Findings Include: 1. During an interview with Resident #18 on 7/27/2011 at 2:15 p.m., she indicated she receives her showers very early in the morning. She indicated this is not her preference, but she feared she wouldn't be able to get a shower if she didn't take one when the CNA (Certified Nursing Assistant) suggested she do so. During review of Resident #'s 18 "ASC-Bath Type Detail Report", on 7/29/11 at 3:15 p.m., the records indicated Residents #18 received showers in the early morning hours. Early shower times for Resident #18 were, 6/28/11 at 2:20 a.m., 7/5/11 at 1:57 a.m., 7/12/11 at 2:38 a.m., 7/20/11 at 3:42 a.m. 2. Resident #68's record was reviewed on 7/26/11 at 5:30 p.m. During an interview with Resident #68 on 7/27/2011 at 9:15 a.m., she indicated she receives showers very early in the morning. She indicated this is not her preference, however this was when the night shift nurse was available to do her wound care and she didn't want to go without the treatment.		significant to the resident. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.Residents that reside in the facility are at risk for the deficient practice. Both residents, 18 and 68, were interviewed to establish shower time preferences. Shower times were adjusted according to resident preferences, the times were then added to the resident shower schedule. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.Facility will conduct an audit of all residents to ensure current shower times are acceptable, and will be changed accordingly. What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.Nursing staff inserviced by Director of Nursing Services on August 17, 18, and 19, 2011 about resident rights regarding shower time preferences and accurate documentation if resident requests a time outside of his or her original preference. Interviews with residents being conducted to ensure shower preference times are being met.Showers are being audited daily for shower times.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	

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	During review of Resident #68 "ASC-Bath Type Detail Report", on 7/29/11 at 3:15 p.m., the records indicated Resident #68 received showers in the early morning hours. Early shower times for Resident #68 were 6/26/11 at 4:12 a.m., 6/28/11 at 1:56 a.m., 7/8/11 at 4:29 a.m., 7/12/11 at 3:06 a.m., 7/13/11 at 1:50 a.m., and 7/14/11 at 2:57 a.m. During an interview with the E.D. (Executive Director) and DNS (Director of Nursing Services) on 7/29/11 at 4:30 p.m., both indicated they have a policy in which resident's choice for shower times is always to be honored. The DNS further included she was made aware by staff, that Resident #68 is a person who prefers to stay up during night time hours and sleeps during day time hours and prefers early morning showers. Documentation of residents preference to showers early was requested from the ED and DNS, on 7/29/11 at 4:45 p.m. As of exit on 8/1/11, no further documentation was provided. During interview on 8/1/11 at 1:45 p.m. a facility policy regarding shower time preference was requested from the ED. The ED indicated the facility did not have a written policy which addressed shower		quality assurance program will be put into place.CQI tool “Accommodation of needs” will be completed weekly times 4, monthly times 2, and quarterly times 2. If threshold not met, action plan will be developed to ensure corrective system is in place.DNS or designee is responsible for monitoring compliance. Any findings will be brought to the QA team on a monthly basis.	

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	preference time. 3.1-3(u)(1)			
F0253 SS=E	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observations and interview, the facility failed to maintain walls, ceiling, equipment and floors in good repair in 15 of 20 resident rooms, affecting 27 residents residing in rooms 101, 103, 105, 106, 107, 109, 128, 201, 205, 206, 207, 328, 324, 319, and 213 In 1 of 4 shower rooms observed, the facility failed to maintain walls, and floors affecting 104 residents who utilized these facilities Findings include: I. During an environmental tour on 7/27/11 at 10:50 A.M. with the Maintenance Supervisor, concerns regarding the following rooms were observed: 1. Room 103 - (2 residents). A fluorescent ceiling light in the bathroom was missing it's cover and the air conditioner located on the west wall of the	F0253	F253 Housekeeping and Maintenance ServicesThis provider ensures that housekeeping and maintenance services are provided to maintain a sanitary, orderly and comfortable interior. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.Room 103- The cover was replaced for the ceiling light in the bathroom and the air conditioner was replaced.Room 107- The holes in the wall have been repaired and re-painted, the drapery tract has been repaired, the air conditioner has been replaced, the ceiling fixture in the bathroom has been replaced and the spackling on the ceiling has been painted.Room 106- The window blind has been replaced, the spackling under the sink has been repainted and the walls in the bathroom have been cleaned.Shower Room E-F- The walls in the shower room have been cleaned, the shower room	08/29/2011

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	room was taped with silver colored tape. 2. Room 107 - (1 resident). There were 2 holes observed measuring 4 X 6 inches and 5 X 6 inches respectively, located on the lower bottom half of the wall on the east side of the room, and 2 holes on the west wall with 1 beneath the air conditioner, and 1 to the left of it, measuring 18 X 6 inches and 24 X 5 inches respectively. Drapery tract for the bed near the door was loose from the ceiling for 10". A silver tape was used around the face of the air conditioner located on the west wall, and the ceiling fixture in the bathroom was cracked along with cracked spackling on the ceiling that was unpainted. 3. Room 106 - (2 residents). There were six slats of the window blind that were broken. The spackling on the wall underneath the bathroom sink was unpainted, and in the bathroom there were dark colored marks on the walls. 4. Shower Room E-F - A brown and black matter was located at the base of the walls throughout 3 stalls in the showering area of the room measuring approximately 12 X 10 feet. A chair, located against the wall behind the showering area was stained with a brown color on the seating and back. Ceramic tiles were missing at		chair has been cleaned and the ceramic tiles at the base of the shower wall has been replaced. Room 206- The spackling underneath the bathroom sink has been re-painted.Room 205- Flaking paint has been removed and area has been repainted.Room 207- The 4 holes in the walls have been repaired and repainted.Room 201- The 4 holes in the walls have been repaired and repainted.Room 128- The flooring in the bathroom will be replaced before 8/29/11.Room 105- The flooring in the bathroom will be replaced before 8/29/11.Room 101- The flooring in the bathroom will be replaced before 8/29/11.Room 109- Flaking paint has been removed and area has been repainted.Room 328- The 5 holes in the walls have been repaired and repainted.Room 324- The flooring in the bathroom will be replaced before 8/29/11.Room 319- The flooring in the bathroom will be replaced before 8/29/11.Room 213- The light fixture in the bathroom has been replaced.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents who reside in the facility are at risk for this alleged practice.What measures will be put into place or systemic changes you will make to ensure that the deficient practice does	

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	.the base of the shower stall wall, nearest the door, measuring 8 X 4 inches. RN #2 was interviewed on 7/29/11 at 4:30 P.M. and indicated 104 residents use this shower room at various times. II. During an environmental tour on 7/28/11 at 3:40 P.M. with the Maintenance Supervisor, concerns regarding the following were observed: 1. Room 206 - (2 residents). Spackling underneath the bathroom sink was not painted in an area measuring 24 X 24 inches. 2. Room 205 - (2 residents). Paint was flaking off the wall in an area covering 8 inches above the bathroom sink. 3. Room 207 - (1 resident). There were 4 holes in the east wall measuring 1/2 inch each. During an interview on 7/29/11 at 11:25 A.M. with the Maintenance Supervisor, he indicated the holes were left from a glove holder that had been relocated. 4. Room 201 - (2 residents). There were 4 holes in the east wall measuring 1/2 inch each. 5. Room 128 - (2 residents). The tile flooring in the bathroom was discolored at the entryway.		not recur.Room rounds will be conducted by managers weekly, findings reported to maintenance for repair or replacement. Managers to be in-serviced on environmental room rounds by Executive Director or designee before 8-29-11 regarding utilization of work orders and the procedure for ensuring requests have been completed.Maintenance will audit 10 rooms per day for environmental concerns.Work orders produced by room rounds of maintenance or managers to be followed up on by Executive director to ensure timely completion.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. CQI tool “Facility Enviornmental Review” will be completed weekly x 4, monthly x 2 and quarterly x 2. If threshold not met, action plan will be developed to ensure the corrective systems are in place.Maintenance supervisor or designee is responsible for monitoring compliance. Any findings will be brought to the QA team on a monthly basis.	

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	6. Room 105 - (2 residents). The tile flooring in the bathroom was discolored around the toilet area measuring 36 X 24 inches. 7. Room 101 - (2 residents). The bathroom tiles on the floor appeared to have various faded colors throughout the room. 8. Room 109 - (2 residents). Paint was flaking just above the sink on the wall in the bathroom in an area measuring 15 X 8 inches. 9. Room 328 - (2 residents). There are 5 holes in the east wall. One behind the bed, door side of the room, measuring 24 X 3 inches, and 4 holes were located behind the headboard, of bed by the window side of the room, measuring 2X 2 inches each. 10. Room 324 - (2 residents). The vinyl flooring in the bathroom was discolored for an area of 36 X 48 inches around the base of the toilet. 11. Room 319 - (1 resident). The flooring under the bathroom sink of brown laminate was loose and coming up in an area measuring 24 X 6 inches.			

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	12. Room 213 - (2 residents). The florescent light fixture located on the bathroom ceiling was cracked. 3.1-19(f)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure comprehensive care plans were developed after being triggered by the Care Area Assessments (CAA) for 3 of 9 residents reviewed for having comprehensive care plans in a sample of 24. (Residents #17, #95 and #106) Findings included: 1. The record of Resident #17 was reviewed on 7/28/11 at 2:20 p.m. Diagnoses for the resident included, but were not limited to, depression and hard of hearing.	F0279	F 279 Develop Comprehensive Care Plans This provider ensures that the provider uses the results of the assessment to develop, review and revise the resident's comprehensive plan of care.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.Residents that reside in the facility are at risk for this deficient practice.Resident #17-care plan updated to include mood and communication.Resident #95-care plan updated to include psychosocial well-being.Resident # 106-care plan updated to include vision and return to community.How will you identify other residents having the	08/29/2011

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	Review of a Significant Change MDS, (Minimum Data Set) (a Resident Assessment Instrument) dated 6/11/11 indicated the resident was tired a lot, had trouble sleeping and was hard of hearing. The Care Area Assessments (CAA'S) for this MDS indicated the resident should have a care plan for mood and communication. A review of the facilities "Work History" on their computer system indicated care plans were to be written. No care plans were found for mood or communication during the record review. During an interview with the Director of Nursing Service (DNS) on 7/28/11 at 5:30 p.m. further information was requested regarding the lack of care plans for mood or communication for Resident #17. On 7/29/11 at 11:00 a.m. the DNS provided a care plan for Mood for the resident, with a start date of 7/29/11, and a care plan for Communication for the resident, with a start date of 7/28/11. She indicated they had not been written prior to these dates. 2. The record of Resident #95 was reviewed on 7/25/11 at 1:15 p.m. Diagnoses for the resident included, but were not limited to, macular degeneration and dementia with hallucinations.		potential to be affected by the same deficient practice and what corrective action will be taken.Facility will complete an audit of residents who reside within the facility to review and revise the resident's comprehensive plans of care.What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.MDS coordinator and Social Service staff inserviced by Staff Development Coordinator on August 22, 2011 to ensure that care plans are developed for residents that trigger Care Area Assessments. Social Services to review other residents residing in the facility to ensure care plans that are triggered by Care area assessments are in place.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.CQI tool "Care Plan Updating" will be completed weekly x 4, monthly x 2 and quarterly x 2. If threshold not met, action plan will be developed to ensure the corrective systems are in place. DNS or designee is responsible for monitoring compliance. Any findings will be brought to QA team on a monthly basis.	

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	Review of an initial MDS Mood/Behavior/Psychosocial assessment dated 6/20/11 indicated the resident had a poor appetite. The CAA'S for this MDS indicated the resident should have a care plan for psychosocial well-being. A review of the facilities "Work History" on their computer system indicated a care plan was to be written. No care plans were found for psychosocial well-being during the record review. During an interview with the DNS on 7/25/11 at 4:30 p.m. further information was requested regarding the lack of a care plan for psychosocial well being Resident # 95. On 7/26/11 at 10:00 a.m. the DNS provided a care plan for "overall well being" with a start date of 7/26/11. She indicated it had not been written prior to this date. 3. The record of resident #106 was reviewed on 7/26/11 at 9:00 a.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus and diabetic neuropathy. Review of an initial MDS dated 6/1/11 indicated, according to the CAA's, care plans for vision and return to the community would be written. No care plans were found for vision or return to			

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	the community during the record review. During an interview with the DNS on 7/26/11 at 7:00 p.m. further information was requested regarding the lack of care plans for vision and return to the community for Resident #106. On 7/2711 at 11:00 a.m. the DNS provided care plans for vision and returning to the community with start dates of 7/27/11. She indicated they had not been written prior to this date. 3.1-35(a)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to provide a therapeutic diet for Residents #12 and #6, as ordered by physician, for 2 of 4 residents reviewed in a sample of 24. Findings include:	F0282	F282 Services by qualified persons/per care plan.This provider ensures that services provided or arranged by the facility is provided by qualified persons in accordance with each resident's written plan of care.What corrective action(s) will be accomplished for those	08/29/2011

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	1. The clinical record for Resident #12 was reviewed on 7/25/11 at 12:30 P.M. Resident #12's diagnoses included, but was not limited to poor oral intake, and a review of weights indicated a 12% weight loss from 5/4/11 to 6/7/11. Review of the physician's order of 7/11/11 indicated that Resident #12 be given 90 milliliters of fluid 3 X daily with meal trays. Review of the physician's order dated 7/11/11 indicated that Resident #12 be given a puree diet with fortified puddings with lunch and supper, and may have pleasure foods (1 item with each meal), and no fluids with pleasure foods, and pudding thick liquids. The physician's order of 6/17/11 indicated the start of 1.5 Jevity continuous at 100 milliliters for 12 hours to stabilize weight. During observation of dinner on 7/26/11 at 5:25 P.M., the resident was served 1 cup of pudding. LPN #1 was assisting Resident #12 with pudding, read physician order, and indicated this resident should have been receiving a pureed food with a liquid drink and a pleasure food. A review of the menu given to the resident when served indicated one pureed item only be given and no fluids.		residents found to have been affected by the deficient practice.Residents that reside in the facility are at risk for the deficient practice.Resident #12 diet orders were evaluated by the RD and order was clarified per recommendations and physician.Resident # 6 diet order was reviewed by Dietary Clinician and meal ticket was updated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.Residents that reside in the facility have the potential to be affected by the alleged deficient practice.Residents with therapeutic diet physician orders were reviewed to ensure compliance. No other residents were identified.What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.Dietary Manager or designee will in-service staff on or before August 29, 2011 regarding reading tray cards and providing items as listed per tray card.Dietary Manager or designee will audit meal service accuracy, each meal 2 times per week, concerning consistency of meal per physician's orders.The interdisciplinary team will review the physician telephone orders Monday-Friday excluding holidays and weekends to monitor altered diet orders. Dietary technician	

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	155072	A. BUILDING 00 B. WING	08/01/2011

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	DON was interviewed on 7/28/11 at 9:55 A.M., and indicated that resident should receive a pureed food at meal time with a drink and a pleasure food. During an observation of lunch on 7/28/11 at 12: 25 P.M., Resident # 12 was served applesauce and pudding. 2. The clinical record for Resident #6 was reviewed on 7/26/11 at 9:45 A.M. Resident #6's diagnoses included, but was not limited to debilitation, with a current care plan for risk of weight loss due to leaving 25 % of meals uneaten. Review of physician's order of 7/11/11 indicated Resident #6 received a regular diet with ice cream at lunch and supper. During observation of dinner on 7/26/11 at 6:00 P.M., resident #6 was served a regular diet with no ice cream. Resident #6 was interviewed and indicated he does not receive ice cream with any of his meals. Resident #6 was observed on 7/28/11 at 1:00 P.M. and did not receive any ice cream with his meal. On 7/29/11 resident #6 was observed at 6:10 P.M. and did not receive any ice cream with his meal. On 8/1/11 at 9:25 A.M., during interview with DON, she indicated resident #6		attends IDT meeting and updates meal ticket at that time. Weekend manager will be responsible for reviewing orders and updating of meal tickets on the weekend.Dietary Manager or designee will update any new diet orders to the meal ticket daily Monday-Friday excluding holidays and weekends. Weekend Manager will be responsible for reviewing orders on the weekend.All physician orders for altered diets have been audited by Dietary Technician to ensure meal tickets are accurate.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.CQI tool “Meal Service Observation” will be completed weekly x 4, monthly x 2 and quarterly x2. If threshold not met, action plan will be developed to ensure the corrective systems are in place.Dietary Manager or designee is responsible for monitoring compliance.Any findings will be brought to the QA team on a monthly basis.	

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	should have received ice cream at lunch and supper and it was not carried over from the physician order to the meal ticket. 3.1-46(a)(2)			
F0309 SS=E	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure bowel movement records were monitored and interventions started for 4 of 5 residents reviewed for bowel care in a sample of 24. (Residents #106, #91, #95 and #87) Findings included: 1. The record of Resident #106 was reviewed on 7/26/11 at 9:00 a.m. Diagnoses for Resident #106 included, but were not limited to, morbid obesity, renal failure, back pain and diabetes mellitus. A recapitulated physician's order for July,	F0309	F309 Provide care/services for highest well being.This provider ensures that each resident is provided the necessary care and services to attain or maintain the highest practical, physical, mental and psychosocial well being.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.Resident #106-Nursing completed a bowel assessment.Resident #91-Nursing completed a bowel assessment.Resident #95-Nursing completed a bowel assessment.Resident #87-Nursing completed a bowel assessment.Nursing staff in-serviced on bowel elimination policy. How will you identify other residents having the potential to	08/29/2011

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	2011, with an original date of 5/26/11, indicated Resident #106 could receive a Dulcolax suppository 10 mg. [milligrams] daily as needed for constipation. Review of the Medication Records for Resident #106 for June and July, 2011, indicated the resident did not receive a Dulcolax suppository for constipation. A Bowel and Bladder Chart Detail Report was received from the Administrator on 7/27/11 at 11:00 a.m. Review of the chart section titled "Did resident have a bowel movement" indicated a "no" was marked for Resident #106 on June 14, 15,16,17,18,19 and June 21, 22, 23, 24, 25 and 26, 2011, and July 13, 14, 15, 16 and 17, 2011. A review of a Minimum Data Set (MDS) dated 6/1/11 indicated Resident #106 was "frequently incontinent" of bowel. Review of a constipation care plan for Resident #106, dated 6/23/11, indicated a goal of "Resident will have a BM at least [every] 3 days." Approaches included, but were not limited to, "Administer laxative as ordered...Record BM's on BM log..." Further information was requested from the Director of Nursing Services (DNS)		be affected by the same deficient practice and what corrective action will be taken.The facility will complete an audit of residents residing in the facility in order to review alleged deficient practice.What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.Nursing staff to be in-serviced by Staff Development coordinator on bowel elimination and documentation policy on or before 8/29/11.DNS or designee reviews bowel elimination record and documentation every day on dayshift, Monday-Friday and if appropriate ensures physicians orders are followed.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.CQI tool “Bowel Elimination” will be completed weekly x 4, monthly x 2, quarterly x 2. If threshold not met, action plan will be developed to ensure the corrective systems are in place.DNS or designee is responsible for monitoring compliance, any findings will be brought to the QA team on a monthly basis.	

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	on 7/27/11 at 5:45 p.m. regarding Resident #106 not having a BM June 14 - 19 and 21 - 26. On 7/28/11 at 10:00 a.m. the DNS indicated she had no further information on bowel movements the resident might have had or laxatives administered. 2. The record of Resident #91 was reviewed on 7/26/11 at 1:00 p.m. Diagnoses for Resident #91 included, but were not limited to, anorexia, depression, pelvic fracture, falls and constipation. She was admitted to the facility on 6/9/11. Review of a hospital discharge summary, dated 6/9/11, received from the Staff Development Coordinator on 7/27/11 at 4:50 p.m. indicated "...The patient, during the hospital stay, had problems with constipation..." Review of recapitulated physician's orders for July, 2011, indicated Resident #91 was to receive Colace 100 mg. twice daily and Dulcolax 5 mg daily for constipation. These orders had an original date of 6/10/11. A constipation care plan for Resident #91, dated 6/27/11, indicated a goal of "Resident will have a soft formed BM at least [every] 3 days." Approaches			

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	included, but were not limited to, "...Document abnormal findings and notify MD..." A "Bowel and Bladder Chart Detail Report was received from the Administrator on 7/27/11 at 11:00 a.m. Review of the chart section titled "Did resident have a bowel movement" indicated a "no" was marked for Resident #91 on June 19, 20, 21, 22, 23 and 24, 2011, and July 13, 14, 15, 16, 17, 18 and 19, 2011. Review of a MDS for Resident #91, dated 6/20/11 indicated she was continent of bowel. Further information was requested from the Director of Nursing Services (DNS) on 7/27/11 at 5:45 p.m. regarding Resident #91 not having a BM June 19 - 24 and July 13 - 19. On 7/28/11 at 10:00 a.m. the DNS indicated she had no further information on bowel movements the resident might have had. 3. The record of Resident #95 was reviewed on 7/25/11 at 1:15 p.m. Diagnoses for Resident #95 included, but were not limited to, dementia with hallucinations and chronic obstructive pulmonary disease.			

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Recapitulated physician's orders for July, 2011, with original order dates of 6/9/11 indicated Resident #95 could receive a Metamucil capsule daily or have Milk of Magnesia 30 milliliters daily as needed for constipation.

A constipation care plan for Resident #95, started 6/27/11, indicated a goal of "Resident will have a soft formed BM at least [every] 3 days." Approaches included, but were not limited to, "...Administer medications as ordered...monitor bowel function..."

A Bowel and Bladder Chart Detail Report was received from the Administrator on 7/27/11 at 11:00 a.m. Review of the chart section titled "Did resident have a bowel movement" indicated a "no" was marked for Resident #95 on June 14, 15, 16, 17, 18, June 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, July 1, 2, 3, 4, 5, 6 and July 8, 9, 10 and 11, 2011.

Review of a MDS for Resident #95, dated 6/20/11 indicated she was continent of bowel.

Review of Medication Records for June and July, 2011 indicated Resident #95 did not receive either Milk of Magnesia or Metamucil at any time.

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	Further information was requested from the Director of Nursing Services (DNS) on 7/27/11 at 5:45 p.m. regarding Resident #95 not having a BM June 14 - 18, June 20 - July 6 and July 8 - 11, 2011. On 7/28/11 at 10:00 a.m. the DNS indicated she had no further information on bowel movements the resident might have had or laxatives administered. 4. The record of Resident #87 was reviewed on 7/27/11 at 1:00 p.m. Diagnoses for Resident #87 included, but were not limited to, probable dementia, depression and adrenal insufficiency. A recapitulated physician's order for July, 2011, with an original order date of 5/4/11, indicated Resident #87 could receive Milk of Magnesia, 30 milliliters daily as needed for constipation. A current constipation care plan for Resident #87, originally dated 10/14/10, indicated a goal of "Resident will have soft formed BM at least every 3rd day." Approaches included, but were not limited to, "...Monitor bowel function an...Administer medications as ordered...Notify MD if no BM after 3rd day..."			

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	A Bowel and Bladder Chart Detail Report was received from the Administrator on 7/27/11 at 11:00 a.m. Review of the chart section titled "Did resident have a bowel movement" indicated a "no" was marked for Resident #87 on June 5, 6, 7, 8, 11, 12, 13, 14, 15, 16, 17, section titled "Did resident have a bowel movement" indicated a "no" was marked for Resident 26, 27, 28, 29, 2011 and July 5, 6, 7, 8, 9, 11, 12, 13, 14, 15 and 16, 2011. Review of an MDS for Resident #87, dated 5/18/11, indicated she was "frequently incontinent" of bowel. Review of Medication Records for June, and July, 2011, indicated Resident #87 did not receive any Milk of Magnesia for constipation in June and did not receive it until July 13, 2011. Further information was requested from the Director of Nursing Services (DNS) on 7/27/11 at 5:45 p.m. regarding Resident #87 not having a BM June 5 - 8, 11 - 17 and 26 - 29, 2011 and July 5 - 9 and 11 - 16, 2011. On 7/28/11 at 10:00 a.m. the DNS indicated she had no further information on bowel movements the resident might have had or laxatives administered. A facility policy, received from the DNS			

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	on 2/28/11 at 10:00 a.m., titled "Bowel Elimination," dated 3/10, indicated "Policy...It is the policy of [name of corporation] to ensure that each resident maintains a safe and healthy bowel elimination pattern...Procedure...5. Bowel movements will be recorded on the facility BM record and/or resident care record daily by the direct care staff. 6. The DNS/designee will assign a charge nurse on a specific shift to review all BM records on a daily basis...8. A resident not having a bowel movement for 3 consecutive days, will be given a laxative or stool softener, as prescribed by the physician, at the end of the 3rd day. 9. Resident (s) not having results from the laxative or stool softener will be given an enema, of ordered by the physician. 10. If by the 4th afternoon, the resident (s) has not had results, the nurse will...notify the physician for further order." 3.1-37(a)			

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F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. 1. Based on interview and record review, the facility failed to ensure weights were done weekly for 4 weeks following a resident's admission for 1 of 12 residents reviewed for having weekly weights done for 4 weeks in a sample 24. (Resident #125) 2. Based on observation, record review and interview, the facility failed to provide a therapeutic diet as ordered by physician for 2 of 12 residents reviewed in a sample of 24. [Residents' # 6 & #12] Findings included: 1. The record of Resident #125 was reviewed on 7/28/11 at 5:30 p.m. Diagnoses for the Resident #125 included, but were not limited to, gastroesophageal reflux disease and diabetes mellitus. The Resident #125 was admitted to the	F0325	F325 Maintain Nutrition Status Unless Unavoidable This provider ensures that residents maintain acceptable parameters of nutritional status unless the resident's clinical condition demonstrates that this is not possible; and receives a therapeutic diet when there is a nutritional problem.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.Resident #125 weight remains stable and will be weighted weekly x's 4Resident # 12 diet orders were evaluated by the RD and order clarified per recommendations and physician. Resident #12 will be weighed weekly x's 4.Resident #6 diet order was reviewed by Dietary Clinician and meal ticket was updated and resident weight is stable.Nursing staff in-serviced by Staff Development coordinator on the facility weight policy.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.Residents who reside in the	08/29/2011

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	facility on 7/11/11. A care plan for the Resident #125, dated 7/6/11, related to therapeutic diet indicated approaches which included, but were not limited to, "Monitor weights." Review of a Weights Detail Report received from the MDS Coordinator (Minimum Data Set) on 7/28/11 at 3:08 p.m. indicated no weights had been done on Resident #125. During an interview with DNS Specialist #5 on 7/29/11 at 9:20 a.m. she indicated no weights had been done on Resident #125 since his admission on 7/11/11. A facility policy dated as reviewed 4/2011, received from the Director of Nursing Services (DNS) on 7/27/11 at 9:30 a.m. indicated "...Procedure The weight flow sheet is to be maintained by the Nursing Department..." During an interview with the DNS on 7/27/11 at 11:45 a.m., she indicated new admissions are to be weighed weekly for 4 weeks. She indicated Resident #125 was weighed on 7/28/11. On 7/28/11 at 12:30 p.m. the DNS provided an untitled document which she indicated was going to be the facility's new policy for resident weights and		facility are at risk for this alleged deficient practice.What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.Residents will be weighed per facility weight policy. Residents with therapeutic diet orders will be reviewed on or before 8/29/11 to ensure compliance.Tracking system developed to ensure compliance.New admissions will have weight obtained weekly for 4 weeks. New admission weights will be reviewed weekly at Nutritionally at Risk meeting to monitor residents weight loss or gain.Dietary Clinician will maintain binder to ensure system is in place. Dietary Manager will in-service dietary staff on or before 8/29/11 to ensure that proper items are being provided per tray card for therapeutic diets.Nursing staff will be in-serviced by Staff Development Coordinator on the weight tracking policy on or before 8/29/11.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.CQI tool-“Resident Weights” will be completed by Dietary Manager on day shift, weekly x 4, monthly x 2 and quarterly x 2. If threshold not met, action plan will be developed to ensure the corrective systems are in place. Any findings will be	

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	weight reviews. The document indicated "All admits/readmits will have an order stating 'Weekly Weights X 4 weeks." 2.a] The clinical record for Resident #12 was reviewed on 7/25/11 at 12:30 P.M. Resident #12's diagnoses included, but was not limited to poor oral intake, and a review of weights indicated a 12% weight loss from 5/4/11 to 6/7/11. The review of physician's order of 7/11/11 indicated Resident #12 be given 90 milliliters of fluids 3 X (times) daily with meal trays. The review of physician's order dated 3/31/11 indicated that the Resident #12 be given a puree diet with fortified puddings with lunch and supper, and pudding thick liquids, and may have a pleasure food (1 item with each meal), with no fluids. On 7/28/11, a list of weights was provided from 2/2011 to 7/2011 which indicated a weight loss of 13 pounds (12%) from 5/4/2011 to 6/7/2011. Physician's order of 6/17/11 indicated the start of 1.5 Jevity continuous at 100 milliliters for 12 hours to stabilize weight. During observation of dinner on 7/26/11 at 5:25 P.M., Resident #12 was served 1 cup of pudding. LPN #1 was assisting Resident #12 with pudding, read physician's order, and indicated this resident should have been receiving a		brought to the QA team on a monthly basis.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pureed food with a liquid drink and a pleasure food. A review of the menu given to Resident #12 when served indicated one pureed item only be given and no fluids. The DON was interviewed on 7/28/11 at 9:55 A.M., and indicated Resident #12 should receive a pureed food at meal time with a drink and a pleasure food. During an observation of lunch on 7/28/11 at 12:25 P.M., Resident # 12 was served applesauce and pudding. 2.b] The clinical record for Resident #6 was reviewed on 7/26/11 at 9:45 A.M. Resident #6's diagnoses included, but was not limited to debilitation. Review of physician's order of 7/11/11 indicated Resident #6 received a regular diet with ice cream at lunch and supper. During observation of dinner on 7/26/11 at 6:00 P.M., Resident #6 was served a regular diet with no ice cream. Resident #6 was interviewed at that time, and indicated that he does not receive ice cream with any of his meals. Resident #6 was observed on 7/28/11 at 1:00 P.M. and did not receive any ice cream with his meal. On 7/29/11 Resident #6 was observed at 6:10 P.M. and did not receive			

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	155072	A. BUILDING 00 B. WING	08/01/2011

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	any ice cream with his meal. On 8/1/11 at 9:25 A.M., during interview with DON, she indicated that Resident #6 should have received ice cream at lunch and supper, and that it was not carried over from the physician order to the meal ticket. 3.1-46(a)(2) 3.1-46(a)(1)			
F0368 SS=F	Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. Based on observation and interview, the facility failed to provide a nourishing	F0368	F368 Frequency Of Meals / Snacks At Bedtime This provider	08/29/2011

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	night time snack to residents. This had the potential to effect 126 residents out of a total of 128 residents who received oral diets. [Residents 125, 68, 28] Findings Include: During an observation of the facility on 7/27/11 at 8:00 p.m., the A-C hall nurses station was observed. At the nurses station were 2 dining room trays with 10-15 fruit filled cookies and 2 pitchers of red "kool-aid" type of beverage. During an interview with Employee #4 on 7/27/11 at 8: 15 p.m., he indicated the facility does normally pass out snacks, but there were some residents who had come to the nurses station to pick them up. He also indicated usually they would provide some type of snack for residents with diabetes, but at this time there were none available. During an observation of the facility on 7/27/11 at 8:25 p.m., the E and F hall nurses station was observed. At the nurses station was 1 dining room tray with 11 fruit filled cookies and 1 pitcher of red "kool-aid" type of beverage. During an interview with Employee #3 on 7/27/11 at 8:30 p.m., she indicated she does not pass night time snacks. She		provides and offers nourishing snacks at bedtime daily to residents.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.Residents #125, #68, #28 is offered a nourishing snack at bedtime daily. Nursing staff, Dietary Clinician and Dietary Manager in-serviced by Staff Development Coordinator regarding policy on HS snacks.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.Residents who reside in the facility are at risk for this alleged deficient practice.What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.Nursing staff and Dietary staff will be in-serviced on or before 8/29/11 on providing snacks at bedtime daily.Dietary Manager will label all HS snacks required for therapuetic diets and assemble for delivery.Once delivered to unit dietary will request Nursing to sign off that snacks are available with a variety offered.Dietary Manager will monitor all snack items and track log sheets to ensure system is in place.Certified Nursing Assistants responsible for delivering and documenting if resident refused or accepted snack in the Care Tracker	

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	indicated there were only a few cookies, and not everyone could have one, and she didn't feel it appropriate to offer to some and not others. She indicated the kitchen staff only brought out a few cookies so she would leave the snacks for the residents that would like to come and get one. She also indicated residents who were diabetic would not be receiving a snack at bed time. During an interview with Resident #125, on 7/27/11 at 8:35 p.m., he indicated that he never is offered a snack, he had been told if he would like he can find it at the nurses station. He also indicated there is never a very "healthy" snack and he would like to have some fresh fruit. During an interview with resident #68, on 7/27/11 at 8:40 p.m. she indicated no one had offered her a snack and didn't know a snack was available. During an interview with Resident #28 on 7/27/11 at 9:00 p.m. she indicated the facility never brings her a snack, she just knew to go to the nurses station. She indicated every "once in a while" they have a snack that is available for diabetic residents to eat. 3.1-21(e)		System. Nurse signs off that C.N.A. completed HS snack requirementsHS snacks specifically given from a physician order are documented by a nurse.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.CQI tool “HS Snacks” will be completed by DNS or designee weekly x 4, monthly x 2 and quarterly x 2. If threshold not met, action plan will be developed to ensure the corrective systems are in place.Any findings will be brought to the Quality Assurance Team	

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F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to prepare, distribute and serve food under sanitary conditions and equipment used to prepare food was maintained in a sanitary condition during 2 of 2 kitchen observations. This had the potential to affect 124 of 128 residents who received meals from the kitchen. Findings Include: During the dietary walk through on 6/25/11 at 11:00 a.m., with the Dietary Manager the following were observed: 1. Dietary Staff # 1 was observed to have facial hair uncovered, as he prepared food, handled the dishes and served the meal. 2. The double door oven used to prepare the noon meal had numerous baked on spills. 3. The wood grain cart held a coffee container, coffee cups which had multiple dry stains and food crumbs on them. 4. One of three ceiling vents located above 4 trays of drinking glasses was dripping. The vent cover had a rust color	F0371	F371 Food Procured/Stored/Prepared under sanitary conditions.This provider will store, prepare, and distribute foods under sanitary conditions.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.Residents who reside in the facility are at risk for this alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.Residents who reside in the facility are at risk for this alleged deficient practice.What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.Dietary Manager or designee will revise cleaning sheets to be more comprehensive.Dietary Manager or designee will monitor cleaning on a daily basis to ensure cleaning is completed.Dietary Manager or designee will assign additional staff members to clean kitchen areas.Dietary staff will be in-serviced by dietary consultant on facial hair policy prior to	08/29/2011

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	substance on the surface. 5. The three shelf cart where the microwave was stored had accumulation of dust, dirt, greasy film, dry food crumbs and sticky to the touch. 6. The three shelf cart where clean plates, glasses, and silverware were stored had accumulation of dust, dirt, greasy film, dry food crumbs and sticky to the touch. 7. The large metal rack near the three compartment sink where pots, pans, skillet and muffin pans were stored had accumulation of dust, dirt, greasy film, dry food crumbs and sticky to the touch. 8. Two of two food preparation tables front and side surface were discolored and sticky to the touch. 9. The plate warmer had accumulation of food crumbs and multiply color dry stains. 10. The tower cart where oven sheet pans were stored had accumulation of dust, dirt, greasy film, dry food crumbs and sticky to the touch. 11. Kitchen serving cart with plastic surface top was discolored, peeling, flaking plastic. The handle and top had unidentifiable debris in the slits. During an interview with the Dietary Manager , she at that time verified the above mentioned observations and had the potential to affect 124 of 128 residents who received meals from the kitchen.		8-29-11.Dietary staff to be in-serviced by dietary consultant regarding sanitation on or before 8/29/11.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.CQI tool-“Sanitation/Environmental Review” will be completed by the Dietary Manager or designee weekly x 4, monthly x 2 and quarterly x 2. If threshold not met, action plan will be developed to ensure the corrective systems are in place. Any findings will be brought to the QA team on a monthly basis.	

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	On 7-29-11 at 6:35 a.m. during breakfast preparation and service the following were observed: 12. Dietary Staff # 2 was observed to have facial hair uncovered, as he prepared food, handled the dishes and served the meal. He wore a cover over his beard but not his mustache. 13. Dietary Staff # 3 was observed to have facial hair uncovered, as he handled the dishes and served the meal. He wore a cover around his neck. 14. Dietary Staff # 1 was observed to have facial hair uncovered, as he prepared breakfast trays, handled dishes and served the meal. 15. Dietary staff # 4 was observed to wipe a three shelf cart off and leave food crumbs on the shelf then place coffee container and cups on the shelf. 16. The following equipment identified as soiled on 7-25-11 during the dietary walk through remained soiled on 7-29-11 during breakfast observation. The double door oven used to prepare noon meal had numerous baked on spills. The wood grain cart had coffee container, coffee cups and supplies had multiple dry stains and food crumbs. The three shelf cart where the microwave was stored had accumulation of dust, dirt, greasy film, dry food crumbs and sticky to the touch.			

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	The three shelf cart where clean plates, glasses, and silverware were stored had accumulation of dust, dirt, greasy film, dry food crumbs and sticky to the touch. The large metal rack near the three compartment sink where pots, pans, skillet and muffin pans were stored had accumulation of dust, dirt, greasy film, dry food crumbs and sticky to the touch. Two of two food preparation tables front and side surface were discolored and sticky to the touch. The plate warmer had accumulation of food crumbs and multiply color dry stains. The tower cart where oven sheet pans were stored had accumulation of dust, dirt, greasy film, dry food crumbs and sticky to the touch. Kitchen serving cart with plastic surface top was discolored, peeling, flaking plastic. The handle and top had unidentifiable debris in the slits. Interview with Dietary Manager on 7-29-11 at 3:00 p.m. indicated it was the facility policy that the dietary staff with facial hair (mustaches and beards) to be covered when in the kitchen. Facial hair should be covered during handling, preparing, and serving food. Dietary Manger indicated that the above mentioned concerns had the potential to affect 124 of 128 residents who received meals from the kitchen.			

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	3.1-21(i)(3)			
F0465 SS=D	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure 1 of 2 dining rooms were in good repair, 1 of 2 doorway entrances were free of gaps, and 1 of 2 washing machines were free of leaks. Findings include: During a tour of the facility on 7/27/11 at 10:50 a.m., with the Maintenance Supervisor, the following concerns were observed: 1. In the primary dining room, located near the front entrance, the ceiling was cracked and unpainted in 2 areas measuring approximately 24 X 18 inches and 18 X 18 inches, each with spackling coming loose from ceiling. The ceiling was also pealing in area located above the ice machine.	F0465	F465 Safe/Functional/Sanitary/Comfortable Enviornment.This provider ensures a safe, functional, sanitary and comfortable environment for residents, staff and the public. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The ceiling was repaired and repainted in the primary dining room. The ceiling above the ice machine was repaired and repainted. The double-doored entrance on the southeast side of the building has been repaired. Repair quote obtained for washing machine. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.Residents that reside in the facility are at risk for the alleged deficient	08/29/2011

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	2. The entrance double doors located on the southeast side of the building had a gap measuring 2 inches wide X 36 inches in length. During interview at that time, the Maintenance Supervisor indicated that these doors were heavily used by ambulance/transportation personnel and were planned to be replaced. 3. In the laundry room, located in the basement, 1 of 2 washing machines was leaking and wet towels were surrounding the base of the machine. During an interview with the Maintenance Supervisor, at that time, he indicated that this machine was on the 2012 budget to be replaced. 3.1-19 (f)		practice. What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.Housekeeping and laundry staff to be in-serviced by Maintenance Director on or before 8/29/11 regarding proper load capacity of the washing machine, and proper sanitary conditions of the laundry room and on how to fill out work orders as needed. Executive Director to receive a copy of work order and follow up to ensure timely completion by maintenance.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.CQI tool-"-"Sanitation/Environmental Review" will be completed by the Maintenance supervisor or designee weekly x 4, monthly x 2 and quarterly x 2. If threshold not met, action plan will be developed to ensure the corrective systems are in place. Any findings will be brought to the QA team on a monthly basis.	
R0000	This Residential Finding is Cited in Accordance with 410 IAC 16.2-5.	R0000	This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Review on or after 8/29/11.	

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R0144	(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to maintain a clean and orderly environment in the residential laundry room for 8 out of 13 residents who use this room to do their laundry. Findings include: During an environmental tour on 7/27/11 at 11:05 with the Maintenance Supervisor, the following observations were made: 1. In the residential laundry room, a liquid dispenser, located next to the washing machine, and connected to it, was dripping a blue colored substance onto the floor which had accumulated. A laundry basket on wheels, located against the wall in front of the machine, contained floor mop heads, and a cart located by the door contained small pieces of cloth. During an interview, at that time, with the Maintenance Supervisor he could not identify the mop heads or cloths as clean or dirty, but indicated the staff also used this room to launder mop heads and rags.	R0144	R0144 Sanitation and Safety Standards This provider ensures that the facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.Residents who use the Assisted Living laundry room are at risk for this alleged deficient practice.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. The liquid dispenser has been replaced. All floor mop heads and cart containing small pieces of cloth have been removed.What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not recur.Housekeeping, laundry staff and Assisted living staff to be in-serviced by maintenance director on or before 8/29/11 regarding proper sanitary conditions of the laundry room.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.CQI	08/29/2011

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			tool-"-"Sanitation/Environmental Review" will be completed by the Maintenance supervisor or designee weekly x 4, monthly x 2 and quarterly x2. If threshold not met, action plan will be developed to ensure the corrective systems are in place. Any findings will be brought to the QA team on a monthly basis"	